Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 21, 2014

Gail Kaminski Potter, Administrator
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404-1397

Dear Ms. Potter,

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 17, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enclosure

PRINTED: 10/28/2014
FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING: _____ B. WING _____	C 10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

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R100	Initial Comments: An unannounced complaint survey was conducted from 10/16/14 - 10/17/14, by the Division of Licensing and Protection, to assess compliance with the Vermont Residential Care Home Licensing Regulations. The following regulatory violations were identified.	R100	Our Lady of Providence submits this Plan of Correction under procedures established under the Vermont Residential Care Home Regulations. This Plan of Correction should not be construed as either a waiver of Our Lady of Providence's right to appeal or an admission of past or ongoing violations of	
R126 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the home failed to assure the necessary services were provided to meet the personal and psychosocial needs for 1 applicable resident in the sample. (Resident #1). Findings include: Per staff and resident interviews throughout the day on 10/16/14 and 10/17/14, Resident #1 had challenging behaviors that included screaming loudly at staff and other residents of the home in a verbally abusive manner; staff were not given the training needed to provide care to met the needs of this challenging resident. The resident was also physically assaultive towards direct care staff at times and used his/her walker to push staff in a threatening manner. The resident was admitted to the home in late April with a history of	R126	regulatory requirements. R126 Resident #1 had an emergent discharge from the facility on 11/1/2014, and will not be re-admitted. Staff will be trained in dealing with challenging behaviors, so that the personal and psycho-social needs of all residents can be met. This will be monitored by the Director of Nursing Services and Administrator. Goal Date: 12/31/2014 R145 The Plan of Care for each resident will be developed, and continually updated to reflect all of their current needs. Nursing staff will be educated on development of the Plan of Care, and revision as new needs	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gaston Patten — TITLE: Administrator — (X6) DATE: 11/7/2014

R126, R145, R150, R191, R200, R208, R219 + R224 POCs accepted 11/20/14 MBoltmRN/PMC

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R126	Continued From page 1 agitated behaviors. The resident was seen monthly by their psychiatrist, accompanied by the DON (Director of Nursing) to these appointments. A behavioral plan was developed by the DON to help staff deal with these behaviors; however, some of the interventions did not work and others were no longer being done. The plan was not effective and fully implemented and staff were not included in the development of the plan. When staff asked administration for help, they were told that they did not approach the resident in the correct manner, per interviews with multiple staff. Administration stated to staff that managing the resident effectively was 'all in the approach'. The resident's behavior included being very manipulative at times and impulsivity. Per staff interviews, including licensed nurses, LNAs (Licensed Nursing Assistants) and care givers, there had been no training provided to them to help them manage Resident #1's agitated behaviors. The resident behaviors included the following: daily periods of screaming loudly at staff and/or residents when her/his needs were not immediately met, physically blocking staff and /or residents, moving about near her, verbalizing threats to staff and/or residents at times. Nurses stated during interviews on both days of survey that other residents had complained to them that Resident #1's loud yelling was very disruptive to them. When the resident was not agitated he/she could be quite pleasant and conversant with staff. Staff were not trained regarding what issues were significant and had a negative impact and needed attention, from issues that were not needing attention. For example, a nursing progress note on 9/19/14 described the resident physically grabbing the LNA and squeezing her/his shoulder	R126	arise or current approaches are not working. The Director of Nursing Services will audit care plans to ensure their completeness. Goal Date: December 31, 2014 R150 Residents shall be re-assessed following any spell of illness or injury. This will include neuro-checks following any head trauma. The professional nursing staff will be re-educated on completing assessments, including performing neuro-checks. The Director of Nursing Service will audit to ensure residents who have experienced an illness or injury have been properly assessed and any follow-up monitoring completed. Goal Date: 12/31/2014 R191 Our Lady of Providence will notify the licensing agency and file the appropriate reports for all items listed in 5.12c. Staff will be in-serviced on the reporting criteria under 5.12c. This will be monitored by the	

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R126	Continued From page 2 and pushing the LNA. The nurse on duty for the 3-11 shift took appropriate action to change the situation. Later that same night, on the 11-7 shift, the nurse threatened to remove the resident's TV from the room because the resident refused to let the nurse turn off the resident's bathroom light. This threat exacerbated the resident's behavior and was not necessary and violated the resident's rights. Staff from other departments in the home were also interviewed and confirmed that the resident was out of control at times and they did not know how to respond to those behaviors; they had not received training. The lack of timely training for staff in managing the resident's behaviors has had a negative impact on the other residents of the home, who have had to listen to the screaming and /or been the victim of the verbal abuse. This was confirmed during confidential interviews with 4 residents on the afternoon of 10/16/14 and the morning of 10/17/14. One resident stated that they were afraid of this resident and others stated that they were distressed by the loud outbursts and aggressive acts. The impact to Resident #1 has also been negative; the resident needed closer monitoring and staff to attempt to engage him/her in more meaningful activities and provide distraction during times of stress. The lack of appropriate, consistent care provision was confirmed with the ADM and the DON at 4 PM on 10/17/14.	R126	Administrator and Director of Nursing Service. Goal Date: 12/31/2014 R200 A policy and procedure will be developed to address the filing of incident reports. Staff will be in-serviced. This will be monitored by the Director of Nursing Service. Goal Date: 12/31/2014 R208 All occurrences of resident-to-resident abuse, including verbal abuse will be reported immediately to the supervisor on duty. All staff will be re-trained. This will be monitored by the Director of Nursing Service and Administrator. Goal Date: 12/31/2014	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for	R145	R219	

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R145	Continued From page 3 each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that the plan of care for 1 applicable resident in the targeted sample was current to address all of the resident's identified needs. (Resident #1), Findings include: Per record review and confirmed during interview with the Director of Nurses (DON) on 10/17/14 at 4 PM, the care plan for Resident #1 did not address the resident's history of multiple falls. The resident uses a walker and is unsteady at times. The initial falls assessment, done at admission to the facility on 4/30/14, noted the resident to be at high risk for falls. Since admission, the resident has had multiple falls, without injury. The resident also has challenging behaviors involving loud outbursts, which may include screaming profanities at staff and other residents of the home. Although there is a behavioral plan in place, it is not current to reflect the actions being taken to manage these behaviors. Per a progress note dated 10/4/14, the resident was observed to be very agitated, with scratches on her/his face and yelling "I'm going to scratch my face off!" The resident has been observed with evidence of facial scratching since that time and there is nothing on the care plan to address this behavior. The resident's behaviors warrant close monitoring by staff at times of agitation to assure that they and other resident's of the home are not negatively impacted and this is not included on the care	R145	Residents' Rights will be upheld at all times. This shall include the right to access a telephone at any time. Staff shall be re-educated on Residents' Rights. The Administrator shall monitor this on an on-going basis. Goal Date: 12/31/2014 R224 Residents shall be free from mental, verbal, or physical abuse, neglect and exploitation. They also shall be free from restraints. Abuse training shall be conducted for all staff. The Director of Nursing Service and Administrator will monitor this on an on-going basis. Goal Date: 12/31/2014	

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R145	Continued From page 4 plan. There are no interventions for staff to monitor closely when the resident is in an agitated state. This was confirmed during interview with the Administrator and DON on 10/17/14 at 4 PM.	R145		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the nurse failed to assure that the resident was reassessed per policy after a fall for 1 applicable resident in the sample on 2 occasions. (Resident #1). Findings include: Per record review on 10/16/14, Resident #1 sustained 2 falls where they reported that they had hit their head to the nurse, per progress notes and incident report review. The dates of the falls were 9/25/14 at 1815 and 9/29/24. On each occasion the nurses documented one set of vital signs only. During interview, at 3 PM on 10/16/14, the DON stated that nurses are expected to perform neuro vital signs per the nursing policy/procedure which states "neuro vital signs (NVS) be performed every 15 minutes for the first hour following any head trauma. If these 4 sets of NVS are WNL (within normal limits) they need only be repeated once a shift for 48 hours." There is a Neurological Assessment Flowsheet to document the findings on. The DON confirmed the nurses failed to complete these assessments	R150		

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R150	Continued From page 5 following reported possible head trauma.	R150		
R191 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file. 5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file. 5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained. 5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent	R191		

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R191	Continued From page 6 to the licensing agency within seventy-two (72) hours. 5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency. 5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to submit written reports of verbal abuse of 2 applicable residents of the home. (Residents # 2 and #3). Findings include: Per record review on 10/16/14/ and 10/17/14, Resident #1 was noted to be verbally abusive to Resident #2 in the home's dining room on 10/6/14. Resident #1 was observed to be yelling loudly, stating "this damned place....." and then yelling at Resident #2 to "shut the hell up". This incident was noted in a progress note dated 10/16/14. On another occasion, a LNA stated that she /he had seen Resident #1 yelling at Resident #3, in the presence of another resident (#4). Resident #4 reported that he/she was upset at the behavior of Resident #1 towards Resident #3. Nurses failed to complete an incident report because they stated they only do them for physical abuse. The DON could not provide a copy of the procedure for completion of incident reports upon request and acknowledged at 5:05 PM on 10/16/14 that the incidents of verbal abuse towards other residents were not reported to the licensing agency. Per review, the facility's Policy/Procedure on Abuse Reporting stated:	R191		

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R191	Continued From page 7 "Verbal Abuse is defined as any oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability." The DON and the charge nurse indicated that they had not considered the verbal assaults of Resident #1 to be abusive, and thus reportable to the licensing agency. Refer also to R208.	R191		
R200 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to have a written policy/procedure to direct staff actions subsequent to resident to resident incidents. The lack of policy has to potential to affect all residents of the home. Findings include: Per staff interview and record reviews, Resident #1 had multiple incidents of being verbally abusive to other residents of the home. During interviews with nursing staff on 10/16/14 and 10/17/14, nurses stated that they complete incident reports for resident to resident incidents where physical abuse occurs, not for when verbal abuse occurs. The DON was asked for the policy	R200		

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R200	Continued From page 8 on incident reports and no policy could be found.	R200		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report incidents of verbal abuse by one resident of the home towards 2 other residents of the home. (Residents #1, 2 and 3). Findings include: Per record review and staff interviews, Resident #1 was verbally abusive to Resident #2 and #3 on at least 2 occasions. Per interview on 10/16/14 at 3:50 PM, the LNA stated that she /he had witnessed the abuse towards Resident #3 on more than one occasion. This had happened in the presence of another Resident, #4, who was visibly upset by this verbal abuse. On 10/6/14, Resident #1 was verbally abusive towards Resident #2 in the dining room of the home, witnessed by staff and other residents of the home, who were distressed by the incident. The home failed to report these events to the licensing	R208		

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R208	Continued From page 9 agency. Nurses interviewed on 10/16/14 confirmed that they do not consistently inform the family members of these incidents of resident to resident verbal abuse. The lack of reporting was also confirmed with the DON during interview on 10/16/14 at 4 PM. Refer also to R191.	R208		
R219 SS=D	VI. RESIDENTS' RIGHTS 6.7 Residents have the right to reasonable access to a telephone for private conversations. Residents shall have reasonable access to the home's telephone except when restricted because of excessive unpaid toll charges or misuse. Restrictions as to telephone use shall be in writing. Any resident may, at the resident's own expense, maintain a personal telephone in his or her own room. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to adhere to one applicable resident's right to have reasonable access to the home's telephone upon request. (Resident #1). Findings include: Per record review on 10/16/14, a nursing progress note stated that Resident #1 was requesting to have the nurse help him/her to make a call to his/her brother at 9 PM on 5/3/14. The resident stated that they wanted to find out what time their brother would be coming to visit the next day. The nurse refused to help and informed the resident that it was too late at night	R219		

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R219	Continued From page 10 to make a phone call. The resident screamed for about a half hour, per the note, "demanding that we call the brother and threatening to report us." Per interview with the Administrator and the DON at 4 PM on 10/17/14, there was no reason that the resident should not have been able to call the brother at that time of night; there are no rules regarding this request. The unreasonable response of the nurse incited and caused needless agitation to Resident #1. This action violated the resident's right to reasonable access to a telephone.	R219		
R224 SS=E	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to assure that residents of the home were free from verbal abuse by one applicable resident of the home on multiple occasions. (Residents #1, 2, 3, 4, 5, 6, 7 and 8). Findings include: Per staff and resident interviews throughout the days of 10/16/14 and 10/17/14, Resident #1 had been verbally abusive to other residents of the home. Staff interviewed on the afternoon of 10/16/14 stated that Resident #1 had been verbally abusive to Resident #2 on 1 occasion and to #3 on more than one occasion. The resident had impulsive screaming behaviors	R224		

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R224	Continued From page 11 towards others, including residents who might be in the area at the time of the outburst. Staff reported that the resident had stood at the doorway to a dying resident's room and yelled loudly, " I hope "Resident #6" dies...I want her to die...why don't you die". Staff struggled to get her /him away from the resident's room. During interview on 10/16/14, one resident, who wished to remain anonymous, said that he/she was frightened by P.C.'s aggressive acts towards staff. Other residents expressed that they were distressed by Resident #1's frequent outbursts.	R224		